LRB-2923

2003 DRAFTING REQUEST

Bill

Received: **06/25/2003**

Received By: **pkahler**

Wanted: **As time permits**

Identical to LRB:

For: **Terese Berceau (608) 266-3784**

By/Representing: **Tom Powell**

This file may be shown to any legislator: **NO**

Drafter: **pkahler**

May Contact:

Addl. Drafters:

Subject: **Insurance - health**

Extra Copies:

Submit via email: **YES**

Requester's email: **Rep.Berceau@legis.state.wi.us**

Carbon copy (CC:) to:

Pre Topic:

No specific pre topic given

Topic:

Allow "any willing provider" to join network

Instructions:

See Attached

Drafting History:

Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/?	pkahler 06/25/2003	jdyer 06/25/2003 jdyer 06/25/2003		_____ _____ _____ _____			
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Vers.	Drafted	Reviewed	Typed	Proofed	Submitted	Jacketed	Required
/1	pkahler 09/15/2003	jdyer 09/16/2003 jdyer 09/24/2003	jfrantze 09/24/2003	_____ _____ _____ _____	sbasford 09/24/2003	lnorthro 09/24/2003	

FE Sent For:

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6-25-3

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RECOMMENDED FOR FULL-TEXT PUBLICATION

Pursuant to Sixth Circuit Rule 206

ELECTRONIC CITATION: 2000 FED App. 0304P (6th Cir.)

File Name: 00a0304p.06

UNITED STATES COURT OF APPEALS

FOR THE SIXTH CIRCUIT

Kentucky Association of Health Plans, Inc.; Advantage Care, Inc.; Aetna Health Plans of Ohio, Inc.; Choicecare Health Plans, Inc.; FHP of Ohio, Inc.; HMPK, Inc.; HPLAN, Inc.; Humana Health Plan, Inc., *Plaintiffs-Appellants,* *v.* George Nichols, III, in his official capacity as Commissioner of the Kentucky Department of Insurance, *Defendant-Appellee.*	No. 98-6308

Appeal from the United States District Court

for the Eastern District of Kentucky at Frankfort.

Nos. 97-00024--Joseph M. Hood, District Judge.

Argued: September 20, 1999

Decided and Filed: September 7, 2000

Before: KENNEDY and NORRIS, Circuit Judges; HOLSCHUH,(*) District Judge.

COUNSEL

ARGUED: Robert N. Eccles, O'MELVENY & MYERS, Washington, D.C., for Appellants. Shaun T. Orme, KENTUCKY DEPARTMENT OF INSURANCE, Frankfort, Kentucky, for Appellee. **ON BRIEF:** Karen M. Wahle, O'MELVENY & MYERS, Washington, D.C., Barbara Reid Hartung, GREENEBAUM, DOLL & MCDONALD, Louisville, Kentucky, for Appellants. Shaun T. Orme, Anna R. Gwinn, KENTUCKY DEPARTMENT OF INSURANCE, Frankfort, Kentucky, for Appellee.

HOLSCHUH, D. J., delivered the opinion of the court, in which NORRIS, J., joined. KENNEDY, J. (pp. 38-61), delivered a separate dissenting opinion with respect to Part III of the majority opinion.

OPINION

HOLSCHUH, District Judge. Plaintiffs are seven health maintenance organizations (HMOs) licensed under the laws of Kentucky, and the Kentucky Association of Health Plans, Inc., a non-profit association organized to promote the business interest of its HMO members (hereinafter referred to as "plaintiffs"). Plaintiffs filed this action against George Nichols III ("defendant"), in his official capacity as Commissioner of the Kentucky Department of Insurance. Plaintiffs argued that Kentucky Revised Statutes Annotated §§ 304.17A-110(3) and 304.17A-171(1)-(8) (Banks-Baldwin 1995), should be found preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), and sought injunctive relief from their enforcement. Both parties moved for summary judgment. The district court denied plaintiffs' request for summary judgment and granted defendant's cross-motion for summary judgment, concluding that §§ 304.17A-110(3) and 304.17A-171(2) were saved from preemption by ERISA because they "regulated insurance" under ERISA's savings clause. Plaintiffs assert that the district court erred in this conclusion.

I. The State Statutes

In 1994, the Kentucky General Assembly enacted the Kentucky Health Care Reform Act (the "Act"). The Act contained an "Any Willing Provider" provision that stated: "Health care benefit plans shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and is willing to meet the terms and conditions for participation established by the health benefit plan." Ky. Rev. Stat. Ann. § 304.17A-110(3) (Banks-Baldwin 1995). The Act defined a health benefit plan as: (repealed)

> [Any] hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; and standard and supplemental health benefit plan as established in KRS 304.17A-160. § 304.17A-100(4)(a) (Banks Baldwin 1995). (repealed)

In 1996, the Kentucky General Assembly added §§ 304.17A-170 and 171 to the code. The additions specifically regulate how "health benefit plans" can interact with chiropractors.(1) Not only does the statute contain an "any willing provider" provision addressed particularly to chiropractors,(2) but it also imposes various additional requirements on health benefit plans that include chiropractic benefits.(3) *See* § 304.17A-171.

In April of 1997, plaintiffs filed suit in the Eastern District of Kentucky, requesting that § 304.17A-110(3) and § 304.17A-171 (for convenience we will collectively refer to § 304.17A-110(3) and § 304.17A-171(2) as Kentucky's (repealed)

"AWP" laws) be declared, among other things, preempted by § 514(a) of ERISA, 29 U.S.C. § 1144(a). Plaintiffs moved for partial summary judgment on the issue and Commissioner Nichols cross-moved for partial summary judgment as well. The district court determined that while the Kentucky AWP laws were related to employee benefit plans under ERISA § 514(a), they regulated the business of insurance and therefore fell under the saving clause of § 514(b), 29 U.S.C. § 1144(b)(2)(A). The court thus granted partial summary judgment in favor of Commissioner Nichols and determined its order to be final and appealable. This appeal followed.

Sections 304.17A-110(3) and 304.17A-100(4)(a) were repealed by the Kentucky legislature effective July 1, 1999. The parties acknowledge that this appeal is not moot, however, as the legislature, through House Bill No. 315 (Ky. 1998), replaced the repealed provisions with the same requirements, but substituted the term "health insurer" for "health benefit plan" in its any willing provider provision, now located at Kentucky Revised Statutes Annotated § 304.17A-270 (Banks-Baldwin 1999). The Bill's definition of "insurer" was codified at Kentucky Revised Statutes Annotated § 304.17A-005(22) (Banks-Baldwin 1999), which defines "insurer" as:

> [A]ny insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider- sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky.

The parties having agreed that this appeal is not rendered moot by the new language used in the present statutes, the court will consider the AWP laws in their present form in the court's analysis of their validity, rather than adjudicating the validity of repealed statutes.

The chiropractic provisions contained in § 304.17A-171 and § 304.17A-170 were left intact by House Bill No. 315 and continue to remain unchanged.

The issue of the potential preemption of §§ 304.17A-270 and 304.17A-171(2) by ERISA is therefore properly before this court.(4) We review a district court's decision to grant summary judgment *de novo*, applying the same test as that employed by the district court. *Wathen v. General Elec. Co.*, 115 F.3d 400, 403 (6th Cir. 1997). Summary judgment is proper if there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. *See Schachner v. Blue Cross & Blue Shield of Ohio*, 77 F.3d 889, 892-93 (6th Cir. 1996).

II. Preemption

We are required by this appeal to define the boundaries of preemption under ERISA § 514 (a) and (b), 29 U.S.C. § 1144(a) and (b). Section 514(a), the preemption provision, reads:

> Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter *relate to* any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title (emphasis added).

Section 514(b)(2)(A), the "savings" provision, reads:

> Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.

Section 514(b)(2)(B), the "deemer" provision, reads:

> Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or

> banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

The federal courts have addressed the scope of ERISA's preemption of State law on numerous occasions; however, the wording of the Act combined with the obvious federalism concerns involved have made it difficult to discern clear boundaries. Many courts, including the Supreme Court, have commented on the vexingly broad and ambiguous nature of the provisions.(5) Despite such interpretational difficulties, we must determine whether Kentucky Revised Statutes Annotated §§ 304.17A-270 and 304.17A-171(2) (Banks-Baldwin 1999) "relate to" employee benefit plans covered by ERISA. If so, then the provisions are preempted, unless they fall under ERISA's saving clause as laws regulating insurance.

ERISA is a comprehensive act designed to regulate employee welfare and pension benefit plans, including those that provide "'medical, surgical, or hospital care or benefits' for plan participants or their beneficiaries 'through the purchase of insurance or otherwise.'" *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 650-51, 115 S. Ct. 1671, 1674, 131 L. Ed. 2d 695, 702 (1995) (discussing and quoting ERISA § 3(1), 29 U.S.C. § 1002(1)). To assure that the regulation of employee welfare benefits would remain an area of exclusive federal concern, Congress passed § 514(a) of ERISA, the preemption provision.

The Supreme Court has specifically found that in passing § 514(a) it was Congress' intent:

> to ensure that plans and plan sponsors would be subject to a uniform body of benefits law; the goal was to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government . . ., [and to prevent] the potential for conflict in substantive law . . . requiring the tailoring of plans and employer conduct to the peculiarities of the law of each jurisdiction.

Travelers, 514 U.S. at 656-57, 115 S. Ct. at 1677, 131 L. Ed. 2d at 706 (alteration in original) (quoting *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142, 111 S. Ct. 478, 484, 112 L. Ed. 2d 474, 486 (1990)). In discussing the preemption provision, the Court has variously noted its extreme breadth, terming it "clearly expansive," "broad [in] scope," "broadly worded," "deliberately expansive," and "conspicuous for its breadth." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.*, 519 U.S. 316, 324, 117 S. Ct. 832, 837, 136 L. Ed. 2d 791, 799 (1997) (internal citations omitted) (reviewing past Supreme Court case law addressing the scope of ERISA's preemption provision). The preemption provision, however, is not without limits. As the Court noted in *Travelers*, § 514(a) preempts all state laws that relate to an employee benefit plan covered by ERISA, but, "[i]f 'relate to' were taken to extend to the furthest stretch of its indeterminancy, then for all practical purposes preemption would never run its course." 514 U.S. at 655, 115 S. Ct. at 1677, 131 L. Ed. 2d at 705.

Thus, to determine whether a law "relates to" an employee benefit plan, the Court has formulated a two part test, under which a "law 'relate[s] to' a covered employee benefit plan for purposes of § 514(a) if it [1] has a *connection with* or [2] *reference to* such plan." *Dillingham*, 519 U.S. at 324, 117 S. Ct. at 837, 136 L. Ed. 2d at 799 (internal quotations and citations omitted) (emphasis added). The district court found, and plaintiffs argue, that the Kentucky AWP provisions both refer to and have a connection with ERISA covered employee benefit plans.(6) We analyze each prong of the "relation to" test in turn.

A. Reference To

The Supreme Court has provided guidance in several cases as to when a law "refers to" ERISA. In *Dillingham* the Court summarized its analysis, stating:

> [W]e have held preempted a law that "impos[ed] requirements by reference to [ERISA]," *District of Columbia v. Washington Bd. of Trade*, 506 U.S. 125, 130-31 (1992); a law that specifically exempted ERISA plans from an otherwise generally applicable garnishment provision, *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825, 828 n.2 (1988); and a common-law cause of action premised on the

Section 13 of HB315

304.17A-270 Nondiscrimination against provider in geographic coverage area.

A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health benefit plan and who is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky state Medicaid program and Medicaid partnerships.

Effective: April 10, 1998

History: Created 1998 Ky. Acts ch. 496, sec. 13, effective April 10, 1998.

Section 1
of HB315

304.17A-005 Definitions for subtitle.

As used in this subtitle, unless the context requires otherwise:

(1) "Association" means an entity, other than an employer-organized association, that has been organized and is maintained in good faith for purposes other than that of obtaining insurance for its members and that has a constitution and bylaws;

(2) "At the time of enrollment" means:

(a) At the time of application for an individual, an association that actively markets to individual members, and an employer-organized association that actively markets to individual members; and

(b) During the time of open enrollment or during an insured's initial or special enrollment periods for group health insurance;

(3) "Base premium rate" means, for each class of business as to a rating period, the lowest premium rate charged or that could have been charged under the rating system for that class of business by the insurer to the individual or small group, or employer as defined in KRS 304.17A-0954, with similar case characteristics for health benefit plans with the same or similar coverage;

(4) "Bona fide association" means an entity as defined in 42 U.S.C. sec. 300gg-91(d)(3);

(5) "Church plan" means a church plan as defined in 29 U.S.C. sec. 1002(33);

(6) "COBRA" means any of the following:

(a) 26 U.S.C. sec. 4980B other than subsection (f)(1) as it relates to pediatric vaccines;

(b) The Employee Retirement Income Security Act of 1974 (29 U.S.C. sec. 1161 et seq. other than sec. 1169); or

(c) 42 U.S.C. sec. 300bb;

(7) (a) "Creditable coverage" means, with respect to an individual, coverage of the individual under any of the following:

1. A group health plan;
2. Health insurance coverage;
3. Part A or Part B of Title XVIII of the Social Security Act;
4. Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928;
5. Chapter 55 of Title 10, United States Code;
6. A medical care program of the Indian Health Service or of a tribal organization;
7. A state health benefits risk pool;
8. A health plan offered under Chapter 89 of Title 5, United States Code;
9. A public health plan, as defined in regulations; or

10. A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C. sec. 2504(e)).

(b) This term does not include coverage consisting solely of coverage of excepted benefits as defined in subsection (11) of this section;

(8) "Eligible individual" means an individual:

(a) For whom, as of the date on which the individual seeks coverage, the aggregate of the periods of creditable coverage is eighteen (18) or more months and whose most recent prior creditable coverage was under a group health plan, governmental plan, or church plan. A period of creditable coverage under this paragraph shall not be counted if, after that period, there was a sixty-three (63) day period of time, excluding any waiting or affiliation period, during all of which the individual was not covered under any creditable coverage;

(b) Who is not eligible for coverage under a group health plan, Part A or Part B of Title XVIII of the Social Security Act (42 U.S.C. secs. 1395j et seq.), or a state plan under Title XIX of the Social Security Act (42 U.S.C. secs. 1396 et seq.) and does not have other health insurance coverage;

(c) With respect to whom the most recent coverage within the coverage period described in paragraph (a) of this subsection was not terminated based on a factor described in KRS 304.17A-240(2)(a), (b), and (c);

(d) If the individual had been offered the option of continuation coverage under a COBRA continuation provision or under KRS 304.18-110, who elected the coverage; and

(e) Who, if the individual elected the continuation coverage, has exhausted the continuation coverage under the provision or program;

(9) "Employer-organized association" means any of the following:

(a) Any entity that was qualified by the commissioner as an eligible association prior to April 10, 1998, and that has actively marketed a health insurance program to its members since September 8, 1996, and which is not insurer-controlled;

(b) Any entity organized under KRS 247.240 to 247.370 that has actively marketed health insurance to its members and that is not insurer-controlled; or

(c) Any entity that is a bona fide association as defined in 42 U.S.C. sec. 300gg-91(d)(3), whose members consist principally of employers, and for which the entity's health insurance decisions are made by a board or committee, the majority of which are representatives of employer members of the entity who obtain group health insurance coverage through the entity or through a trust or other mechanism established by the entity, and whose health insurance decisions are reflected in written minutes or other written documentation.

Except as provided in KRS 304.17A-200, 304.17A.210, and 304.17A-220, no employer-organized association shall be treated as an association, small group, or large group under this subtitle;

(10) "Employer-organized association health insurance plan" means any health insurance plan, policy, or contract issued to an employer-organized association, or to a trust established by one (1) or more employer-organized associations, or providing coverage solely for the employees, retired employees, directors and their spouses and dependents of the members of one (1) or more employer-organized associations;

(11) "Excepted benefits" means benefits under one (1) or more, or any combination thereof, of the following:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics;

(h) Other similar insurance coverage, specified in administrative regulations, under which benefits for medical care are secondary or incidental to other insurance benefits;

(i) Limited scope dental or vision benefits;

(j) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof;

(k) Such other similar, limited benefits as are specified in administrative regulations;

(l) Coverage only for a specified disease or illness;

(m) Hospital indemnity or other fixed indemnity insurance;

(n) Benefits offered as Medicare supplemental health insurance, as defined under section 1882(g)(1) of the Social Security Act;

(o) Coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code; and

(p) Coverage similar to that in paragraphs (n) and (o) of this subsection that is supplemental to coverage under a group health plan;

(12) "Governmental plan" means a governmental plan as defined in 29 U.S.C. sec. 1002(32);

(13) "Guaranteed acceptance program participating insurer" means an insurer that is required to or has agreed to offer health benefit plans in the individual market to guaranteed acceptance program qualified individuals under KRS 304.17A-400 to 304.17A-480;

(14) "Guaranteed acceptance program plan" means a health benefit plan in the individual market issued by an insurer that provides health benefits to a guaranteed acceptance program qualified individual and is eligible for assessment and refunds under the guaranteed acceptance program under KRS 304.17A-400 to 304.17A-480;

(15) "Guaranteed acceptance program" means the Kentucky Guaranteed Acceptance Program established and operated under KRS 304.17A-400 to 304.17A-480;

(16) "Guaranteed acceptance program qualified individual" means an individual who, on or before December 31, 2000:

(a) Is not an eligible individual;

(b) Is not eligible for or covered by other health benefit plan coverage or who is a spouse or a dependent of an individual who:

1. Waived coverage under KRS 304.17A-210(2); or

2. Did not elect family coverage that was available through the association or group market;

(c) Within the previous three (3) years has been diagnosed with or treated for a high-cost condition or has had benefits paid under a health benefit plan for a high-cost condition, or is a high risk individual as defined by the underwriting criteria applied by an insurer under the alternative underwriting mechanism established in KRS 304.17A-430(3);

(d) Has been a resident of Kentucky for at least twelve (12) months immediately preceding the effective date of the policy; and

(e) Has not had his or her most recent coverage under any health benefit plan terminated or nonrenewed because of any of the following:

1. The individual failed to pay premiums or contributions in accordance with the terms of the plan or the insurer had not received timely premium payments;

2. The individual performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact under the terms of the coverage; or

3. The individual engaged in intentional and abusive noncompliance with health benefit plan provisions;

(17) "Guaranteed acceptance plan supporting insurer" means either an insurer, on or before December 31, 2000, that is not a guaranteed acceptance plan participating insurer or is a stop loss carrier, on or before December 31, 2000, provided that a guaranteed acceptance plan supporting insurer shall not include an employer-sponsored self-insured health benefit plan exempted by ERISA;

(18) "Health benefit plan" means any hospital or medical expense policy or certificate; nonprofit hospital, medical-surgical, and health service corporation contract or certificate; provider sponsored integrated health delivery network; a self-insured plan or a plan provided by a multiple employer welfare arrangement, to the extent permitted by ERISA; health maintenance organization contract; or any health benefit plan that affects the rights of a Kentucky insured and bears a reasonable relation to Kentucky, whether delivered or issued for delivery in Kentucky, and does not include policies covering only accident, credit, dental, disability income, fixed indemnity medical expense reimbursement policy, long-term care, Medicare supplement, specified disease, vision care, coverage issued as a

supplement to liability insurance, insurance arising out of a workers' compensation or similar law, automobile medical-payment insurance, insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance, short-term coverage, student health insurance offered by a Kentucky-licensed insurer under written contract with a university or college whose students it proposes to insure, medical expense reimbursement policies specifically designed to fill gaps in primary coverage, coinsurance, or deductibles and provided under a separate policy, certificate, or contract, or coverage supplemental to the coverage provided under Chapter 55 of Title 10, United States Code, or limited health service benefit plans;

(19) "Health care provider" or "provider" means any facility or service required to be licensed pursuant to KRS Chapter 216B, pharmacist as defined pursuant to KRS Chapter 315, and any of the following independent practicing practitioners:

(a) Physicians, osteopaths, and podiatrists licensed under KRS Chapter 311;

(b) Chiropractors licensed under KRS Chapter 312;

(c) Dentists licensed under KRS Chapter 313;

(d) Optometrists licensed under KRS Chapter 320;

(e) Physician assistants regulated under KRS Chapter 311;

(f) Advanced registered nurse practitioners licensed under KRS Chapter 314; and

(g) Other health care practitioners as determined by the department by administrative regulations promulgated under KRS Chapter 13A;

(20) (a) "High-cost condition," pursuant to the Kentucky Guaranteed Acceptance Program, means a covered condition in an individual policy as listed in paragraph (c) of this subsection or as added by the commissioner in accordance with KRS 304.17A-280, but only to the extent that the condition exceeds the numerical score or rating established pursuant to uniform underwriting standards prescribed by the commissioner under paragraph (b) of this subsection that account for the severity of the condition and the cost associated with treating that condition.

(b) The commissioner by administrative regulation shall establish uniform underwriting standards and a score or rating above which a condition is considered to be high-cost by using:

1. Codes in the most recent version of the "International Classification of Diseases" that correspond to the medical conditions in paragraph (c) of this subsection and the costs for administering treatment for the conditions represented by those codes; and

2. The most recent version of the questionnaire incorporated in a national underwriting guide generally accepted in the insurance industry as designated by the commissioner, the scoring scale for which shall be established by the commissioner.

(c) The diagnosed medical conditions are: acquired immune deficiency syndrome (AIDS), angina pectoris, ascites, chemical dependency cirrhosis of the liver, coronary insufficiency, coronary occlusion, cystic fibrosis, Friedreich's ataxia, hemophilia, Hodgkin's disease, Huntington chorea, juvenile diabetes, leukemia, metastatic cancer, motor or sensory aphasia, multiple sclerosis, muscular dystrophy, ~~myasthenia gravis, myotonia, open heart surgery, Parkinson's disease, polycystic~~ kidney, psychotic disorders, quadriplegia, stroke, syringomyelia, and Wilson's disease;

(21) "Index rate" means, for each class of business as to a rating period, the arithmetic average of the applicable base premium rate and the corresponding highest premium rate;

(22) "Individual market" means the market for the health insurance coverage offered to individuals other than in connection with a group health plan;

(23) "Insurer" means any insurance company; health maintenance organization; self-insurer or multiple employer welfare arrangement not exempt from state regulation by ERISA; provider-sponsored integrated health delivery network; self-insured employer-organized association, or nonprofit hospital, medical-surgical, dental, or health service corporation authorized to transact health insurance business in Kentucky;

(24) "Insurer-controlled" means that the commissioner has found, in an administrative hearing called specifically for that purpose, that an insurer has or had a substantial involvement in the organization or day-to-day operation of the entity for the principal purpose of creating a device, arrangement, or scheme by which the insurer segments employer groups according to their actual or anticipated health status or actual or projected health insurance premiums;

(25) "Kentucky Access" has the meaning provided in KRS 304.17B-001(17);

(26) "Large group " means:

(a) An employer with fifty-one (51) or more employees; or

(b) An affiliated group with fifty-one (51) or more eligible members;

(27) "Managed care" means systems or techniques generally used by third-party payors or their agents to affect access to and control payment for health care services and that integrate the financing and delivery of appropriate health care services to covered persons by arrangements with participating providers who are selected to participate on the basis of explicit standards for furnishing a comprehensive set of health care services and financial incentives for covered persons using the participating providers and procedures provided for in the plan;

(28) "Market segment " means the portion of the market covering one (1) of the following:

(a) Individual;

(b) Small group;

(c) Large group; or

(d) Association;

(29) "Provider network" means an affiliated group of varied health care providers that is established to provide a continuum of health care services to individuals;

(30) "Provider-sponsored integrated health delivery network" means any provider-sponsored integrated health delivery network created and qualified under KRS 304.17A-300 and KRS 304.17A-310;

(31) "Purchaser" means an individual, organization, employer, association, or the Commonwealth that makes health benefit purchasing decisions on behalf of a group of individuals;

(32) "Rating period" means the calendar period for which premium rates are in effect. A rating period shall not be required to be a calendar year;

(33) "Restricted provider network" means a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of the providers that have entered into a contractual arrangement with the insurer to provide health care services to covered individuals;

(34) "Self-insured plan" means a group health insurance plan in which the sponsoring organization assumes the financial risk of paying for covered services provided to its enrollees;

(35) "Small employer" means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least two (2) but not more than fifty (50) employees on business days during the preceding calendar year and who employs at least two (2) employees on the first day of the plan year;

(36) "Small group" means:

(a) A small employer with two (2) to fifty (50) employees; or

(b) An affiliated group or association with two (2) to fifty (50) eligible members; and

(37) "Standard benefit plan" means the plan identified in KRS 304.17A-250.

(38) "Telehealth" has the meaning provided in KRS 311.550.

Effective: July 15, 2002

History: Amended 2002 Ky. Acts ch. 351, sec. 1, effective July 15, 2002. -- Amended 2000 Ky. Acts ch. 376, sec. 6, effective July 15, 2001; ch. 476, sec. 17, effective July 14, 2000; and ch. 521, sec. 1, effective July 14, 2000. -- Created 1998 Ky. Acts ch. 496, sec. 1, effective April 10, 1998.

Section 7 of HB315

304.17A-250 Standard health benefit plan -- Condition of insurer offering plans -- Benefits comparison -- Writing requirement for provider participation -- Time limit for rate quote -- Notice of denial of coverage.

(1) The commissioner shall, by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan that shall provide health insurance coverage in the individual and small group markets after June 30, 1998. As a condition of doing business in the small group market in the Commonwealth, the health insurer shall offer the standard health benefit plan, but the extent to which the standard health benefit plan shall be offered on a guaranteed issue basis shall only be as provided in KRS 304.17A-200. As a condition of doing business in the individual market on or after January 1, 2001, a health insurer shall offer the standard health benefit plan. Except as may be necessary to coordinate with changes in federal law, the commissioner shall not alter, amend, or replace the standard health benefit plan more frequently than annually. Initially, the standard health benefit plan shall be the standard high plan in effect on April 10, 1998.

(2) The standard health benefit plan shall be available in at least one (1) of these four (4) forms of coverage:

(a) A fee-for-service product type;

(b) A health maintenance organization type;

(c) A point-of-service type; and

(d) A preferred provider organization type.

(3) The standard health benefit plan shall be defined so that it meets the requirements of KRS 304.17B-021 for inclusion in calculating assessments and refunds under Kentucky Access.

(4) Any health insurer who elects to offer health insurance policies in the individual or small group markets in this state shall, as a condition of offering health benefit plans in this state after June 30, 1998, offer and issue the standard health benefit plan in the individual or small group markets in each and every form of coverage that the health insurer offers to sell.

(5) Nothing in this section shall be construed:

(a) To require a health insurer to offer a standard health benefit plan in a form of coverage that the health insurer has not selected;

(b) To prohibit a health insurer from offering other health benefit plans in the individual or small group markets in addition to the standard health benefit plan; or

(c) To require that a standard health benefit plan have guaranteed issue, renewability, or pre-existing condition exclusion rights or provisions that are more generous to the applicant than the health insurer would be required to provide under KRS 304.17A-200, 304.17A-220, 304.17A.230, and 304.17A-240.

(6) Insurance agents licensed under this chapter who present for sale any health benefit plan in the individual or small group markets to a prospective applicant shall also inform that

person of the existence of the standard benefit plan in the same form of coverages offered by the same insurer.

(7) (a) A benefits comparison shall be delivered to a prospective applicant for any health insurance coverage in the individual or small group markets at the time of initial solicitation through means that prominently direct the attention of the prospective applicant to the document and its purpose.

1. The commissioner shall prescribe a standard format, including style, arrangement, and overall appearance, and the content of a benefits comparison.
2. In the case of agent solicitations, an agent shall deliver the benefits comparison to the prospective applicant prior to the presentation of an application or enrollment form.
3. In the case of direct response solicitations, the benefits comparison shall be presented in conjunction with any application or enrollment form.

(b) The benefits comparison given to a prospective applicant shall include:

1. A description of the principal benefits and coverage provided in the standard health benefit plan offered under this section, and the health benefit policy being offered to the prospective applicant;
2. A statement of the principal exclusions, reductions, and limitations contained in the standard health benefit plan offered under this section, and the health benefit plan being offered to the prospective applicant; and
3. A chart providing a direct comparison of the insurer's premium rate for the standard health benefit plan offered under this section, and the health benefit policy being offered to the prospective applicant.

(c) At the time of the execution of an application for any health benefit plan, the prospective applicant shall sign a statement contained in or accompanying the application, which shall remain on file with the health insurer for five (5) years, indicating that the insured has been provided with and understands the benefits comparison required by this subsection.

(d) As used in this subsection and in subsection (6) of this section, the term "prospective applicant" refers only to a natural person who is a resident of the Commonwealth and who is purchasing health insurance coverage in the individual market providing benefits to that person, that person's spouse, or that person's children. It does not include an employer or representative of an employer who is considering health insurance coverage that would provide benefits to employees and their families.

(8) All health benefit plans shall cover hospice care at least equal to the Medicare benefits.

(9) All health benefit plans shall coordinate benefits with other health benefit plans in accordance with the guidelines for coordination of benefits prescribed by the commissioner as provided in KRS 304.18-085.

(10) Every health insurer of any kind, nonprofit hospital, medical-surgical, dental and health service corporation, health maintenance organization, or provider-sponsored health delivery network that issues or delivers an insurance policy in this state that directs or gives any incentives to insureds to obtain health care services from certain health care providers shall not imply or otherwise represent that a health care provider is a participant in or an affiliate of an approved or selected provider network unless the health care provider has agreed in writing to the representation or there is a written contract between the health care provider and the insurer or an agreement by the provider to abide by the terms for participation established by the insurer. This requirement to have written contracts shall apply whenever an insurer includes a health care provider as a part of a preferred provider network or otherwise selects, lists, or approves certain health care providers for use by the insurer's insureds. The obligation set forth in this section for an insurer to have written contracts with providers selected for use by the insurer shall not apply to emergency or out-of-area services.

(11) A self-insured plan may select any third party administrator licensed under KRS 304.9-052 to adjust or settle claims for persons covered under the self-insured plan.

(12) Any health insurer that fails to issue a premium rate quote to an individual within thirty (30) days of receiving a properly completed application request for the quote shall be required to issue coverage to that individual and shall not impose any pre-existing conditions exclusion on that individual with respect to the coverage. Each health insurer offering individual health insurance coverage in the individual market in the Commonwealth that refuses to issue a health benefit plan to an applicant or insured with a disclosed high-cost condition as specified in KRS 304.17B-001 or for any reason, shall provide the individual with a denial letter within twenty (20) working days of the request for coverage. The letter shall include the name and title of the person making the decision, a statement setting forth the basis for refusing to issue a policy, a description of Kentucky Access, and the telephone number for a contact person who can provide additional information about Kentucky Access.

(13) If a standard health benefit plan covers services that the plan's insureds lawfully obtain from health departments established under KRS Chapter 212, the health insurer shall pay the plan's established rate for those services to the health department.

(14) No individually insured person shall be required to replace an individual policy with group coverage on becoming eligible for group coverage that is not provided by an employer. In a situation where a person holding individual coverage is offered or becomes eligible for group coverage not provided by an employer, the person holding the individual coverage shall have the option of remaining individually insured, as the policyholder may decide. This shall apply in any such situation that may arise through an association, an affiliated group, the Kentucky state employee health insurance plan, or any other entity.

Effective: January 1, 2001

History: Amended 2000 Ky. Acts ch. 476, sec. 21, effective January 1, 2001. -- Created 1998 Ky. Acts ch. 496, sec. 7, effective April 10, 1998.

Section 30 of HB315

304.17A-525 Standards for provider participation – Mechanisms for consideration of provider applications – Policy for removal or withdrawal.

(1) Insurers shall establish relevant, objective standards for initial consideration of providers and for providers to continue as a participating provider in the plan. Standards shall be reasonably related to services provided. Selection or participation standards based on the economics or capacity of a provider's practice shall be adjusted to account for case mix, severity of illness, patient age and other features that may account for higher-than- or lower-than-expected costs. All data profiling or other data analysis pertaining to participating providers shall be done in a manner which is valid and reasonable. Plans shall not use criteria that would allow an insurer to avoid high-risk populations by excluding providers because they are located in geographic areas that contain populations or providers presenting a risk of higher-than-average claims, losses, or health services utilization or that would exclude providers because they treat or specialize in treating populations presenting a risk of higher-than-average claims, losses, or health services utilization.

(2) Each insurer shall establish mechanisms for soliciting and acting upon applications for provider participation in the plan in a fair and systematic manner. These mechanisms shall, at a minimum, include:

(a) Allowing all providers who desire to apply for participation in the plan an opportunity to apply at any time during the year or, where an insurer does not conduct open continuous provider enrollment, conducting a provider enrollment period at least annually with the date publicized to providers located in the geographic service area of the plan at least thirty (30) days in advance of the enrollment periods; and

(b) Making criteria for provider participation in the plan available to all applicants.

(3) If a managed care plan terminates the participation of an enrollee's primary care provider, the plan shall provide notice to the enrollee and arrange for the enrollee's continuity of care with an approved primary care provider.

(4) An insurer that offers a managed care plan shall establish a policy governing the removal of and withdrawal by health care providers from the provider network that includes the following:

(a) The insurer shall inform a participating health care provider of the insurer's removal and withdrawal policy at the time the insurer contracts with the health care provider to participate in the provider network, and when changed thereafter;

(b) If a participating health care provider's participation will be terminated or withdrawn prior to the date of the termination of the contract as a result of a professional review action, the insurer and participating health care provider shall comply with the standards in 42 U.S.C. sec. 11112; and

(c) If the insurer finds that a health care provider represents an imminent danger to an individual patient or to the public health, safety, or welfare, the medical director shall promptly notify the appropriate professional state licensing board.

Effective: April 10, 1998

History: Created 1998 Ky. Acts ch. 496, sec. 30, effective April 10, 1998.

806 KAR 17:180. Standard health benefit plan and comparison format.

RELATES TO: KRS 304.17A-080, 304.17A-200 through 304.17A-250, 304.17A-430

STATUTORY AUTHORITY: KRS 304.2-110(1), 304.17A-250(1), (7)(a)1

NECESSITY, FUNCTION, AND CONFORMITY: KRS 304.2-110(1) authorizes the commissioner to promulgate administrative regulations necessary for or as an aid to the effectuation of any provisions of the Kentucky Insurance Code as defined in KRS 304.1-010. KRS 304.17A-250(1) requires the commissioner to define by administrative regulation one (1) standard health benefit plan that shall provide health insurance coverage in the individual and small group markets. KRS 304.17A-250(7)(a)1 requires the commissioner to prescribe a standard format for comparison of the standard plan benefits to other offered comparable plans and requires that the benefit comparison format include style, arrangement, overall appearance, and content of the benefit comparisons. This administrative regulation establishes one (1) standard health plan that shall provide health insurance coverage in the individual and small group markets and prescribes a standard format for comparison of the standard plan benefits to other offered comparable plans.

Section 1. Definitions. (1) "FFS" means a fee-for-service product type.

(2) "HMO" means a health maintenance organization product type.

(3) "POS" means a point-of-service product type.

(4) "PPO" means a preferred provider organization product type.

(5) "Standard health benefit plan" means the format, cost-sharing levels, definitions, benefits, exclusions, and supplemental benefit riders established by the Department of Insurance and the Health Insurance Advisory Council in accordance with KRS 304.17A-250 and any other health insurance benefit mandated by the General Assembly.

Section 2. Standard Benefits Comparison Format. (1) If initial solicitation of health insurance coverage in the individual or nonemployer small group markets occurs, the person soliciting the product shall complete and deliver a benefit comparison form applicable to the product being solicited as follows:

(a) A FFS health benefit plan shall be compared to the FFS standard benefit plan by using the Fee-for-Service Health Benefit Plan Comparison Form;

(b) A HMO health benefit plan shall be compared to the HMO standard benefit plan by using the HMO Health Benefit Plan Comparison Form;

(c) A POS health benefit plan shall be compared to the POS standard benefit plan by using the POS Health Benefit Plan Comparison Form; and

(d) A PPO health benefit plan shall be compared to the PPO standard benefit plan by using the PPO Health Benefit Plan Comparison Form.

(2) An insurer shall produce each form required by subsection (1) of this section and supply each form to each person who solicits health insurance coverage for the insurer in the individual and nonemployer small group markets.

(3) In lieu of using a form required by subsection (1) of this section, an insurer may use a form that is substantially similar to a comparison form incorporated by reference into this administrative regulation. An insurer may modify a benefit comparison form required by subsection (1) of this section in a manner that shall:

(a) Provide additional comparative information;

(b) Compare multiple health benefit plans; or

(c) Disclose that a sample premium comparison is shown on the benefit comparison form and inform the prospective applicant that a specific premium shall be provided upon receipt of the information necessary to generate an accurate comparison.

(4) For each product type listed in subsection (1) of this section:

(a) The person soliciting health insurance coverage shall compare the exclusions contained in "The Kentucky Standard Health Benefit Plan" to the exclusions in the health benefit plan being solicited by using the "Kentucky Standard Health Benefit Plan Comparison Form: Exclusions". In lieu of using this exclusion comparison form, the insurer may use a form that is substantially similar to the "Kentucky Standard Health Benefit Plan Comparison Form: Exclusions."

(b) With respect to the exclusions comparison form required pursuant to subsection (4)(a) of this section, the person soliciting health insurance coverage shall:

1. Witness the signature of the prospective applicant on the exclusions comparison form;

2. Sign the exclusions comparison form;

3. Date the exclusions comparison form as of the date of solicitation; and

4. Attach the exclusions comparison form to the applicable product comparison form completed pursuant to subsection (1) of this section.

(c) The person soliciting health insurance coverage shall deliver a copy of each completed benefit comparison form, together with a copy of the completed and signed exclusions comparison form, to the prospective applicant and to the insurer whose product is being solicited.

(d) Paragraph (b) of this subsection shall not apply to a direct response solicitation. The exclusions comparison form for a direct response solicitation shall be presented to the prospective applicant in accordance with KRS 304.17A-250(7)(a)3.

(5) A benefit comparison form shall not be required if an insurer is marketing only the standard health benefit plan.

Section 3. Modification Process. (1) The standard health benefit plan and each comparison form shall remain in effect until the plan or any form is modified in accordance with the procedures established by this section.

(2) The standard health benefit plan and each comparison form may be modified each year and each modification shall apply to each policy or certificate issued or renewed on or after July 15 of each year.

(3) Any interested person wishing to make a recommendation for modification of the standard plan shall:

(a) Submit their recommendation, in writing, to the Kentucky Department of Insurance, Division of Health Insurance Policy and Managed Care, by August 31 of the year preceding the year in which each modification is recommended for implementation;

(b) Explain the need for each recommended modification; and

(c) Provide a statement regarding the cost effect of each recommended modification.

(4) Within a reasonable time after August 31 of each year:

(a) The department shall present each recommendation for modification received pursuant to subsection (3) of this section to the Health Insurance Advisory Council for consideration;

(b) The Health Insurance Advisory Council shall review and discuss each recommendation for modification of the standard health benefit plan in accordance with KRS 304.17A-080(3);

(c) The Health Insurance Advisory Council shall make a final recommendation for modification of the standard health benefit plan based on the recommendations presented by the department pursuant to paragraph (a) of this subsection; and

(d) After considering the final recommendation for modification from the Health Insurance Advisory Council, the department shall either accept or decline, in writing, to modify the standard health benefit plan.

(5) Each insurer issuing, delivering, or renewing a health benefit plan shall:

(a) Implement each modification to the standard health benefit plan and each benefit comparison form prescribed by the department; and

(b) Amend each policy form and rate filing to include every modification to the standard health benefit plan and each benefit comparison form.

Section 4. Material Incorporated by Reference. (1) The following material is incorporated by reference:

(a) "Fee-for-Service Health Benefit Plan Comparison Form (2002 Edition)";

(b) "HMO Health Benefit Plan Comparison Form (2002 Edition)";

(c) "POS Health Benefit Plan Comparison Form (2002 Edition)";

(d) "PPO Health Benefit Plan Comparison Form (2002 Edition)";

(e) "Kentucky Standard Health Benefit Plan Comparison Form: Exclusions (2002 Edition)"; and

(f) "The Kentucky Standard Health Benefit Plan", HIPMC-SP1 (07/02).

(2) This material may be inspected, copied, or obtained, subject to applicable copyright law, at the Kentucky Department of Insurance, 215 West Main Street, Frankfort, Kentucky 40601, Monday through Friday, 8 a.m. to 4:30 p.m. Forms may also be obtained on the department's Internet web site at www.doi.state.ky.us. (25 Ky.R. 961; Am. 1400; eff. 1-19-99; 27 Ky.R. 2235; 2780; eff. 4-9-2001; 28 Ky.R. 1227; 1648; eff. 1-14-2002; 29 Ky.R. 1373; 1803; eff. 1-16-2003.)

304.17A-170 Definitions for KRS 304.17A-170 and 304.17A-171.

As used in this section and KRS 304.17A-171, unless the context requires otherwise:

(1) "Health benefit plan" has the meaning provided in KRS 304.17A-005.

(2) "Primary chiropractic provider" means a chiropractor licensed pursuant to KRS Chapter 312 who has been selected by a person covered by a health benefit plan to provide chiropractic service and who agrees to provide within the statutory scope of their respective practices these services in accordance with the terms, conditions, reimbursement rates, and standards of quality as set forth within the specific health benefit plan.

(3) "Participating chiropractic provider" means a primary chiropractic provider who has contracted with a health insurer to provide chiropractic services within the proper scope of practice to persons insured under the health benefit plan of the insurer.

(4) "Chiropractic benefits" means those services that are provided by a primary chiropractic provider who is functioning within the statutory scope of practice.

(5) "Gatekeeper system" means a system of administration used by any health benefit plan in which a primary care provider furnishes basic patient care and coordinates diagnostic testing, indicated treatment, and specialty referral for persons covered by the health benefit plan.

(6) "Gatekeeper" means a covered person's primary care provider in a gatekeeper system.

(7) "Health care insurer" means any entity, including but not limited to insurance companies, hospital and medical services corporations, health maintenance organizations, preferred provider organizations, and physician hospital organizations, that is authorized by the state of Kentucky to offer or provide health benefit plans, policies, subscriber contracts, or any other contracts of similar nature which indemnify or compensate health care providers for the provision of health care services.

(8) "Covered persons" means any individual or family who is enrolled in a health benefit plan or policy from a health care insurer and on whose behalf the health care insurer is obligated to pay for or provide chiropractic services.

(9) "Covered service" means those health care services including chiropractic services which the health care insurer is obligated to pay for or provide to covered persons under the health benefit plan or policy or pursuant to KRS 304.17-305 or 304.18-095.

Effective: April 10, 1998

History: Amended 1998 Ky. Acts ch. 496, sec. 51, effective April 10, 1998. -- Created 1996 Ky. Acts ch. 187, sec. 1, effective July 15, 1996.

304.17A-171 Requirements for health benefit plans that include chiropractic benefits.

A health benefit plan that includes chiropractic benefits shall:

(1) Include all primary chiropractic providers who are selected by covered persons of the plan for the provision of all chiropractic benefits provided by the plan which fall within the statutory scope of practice of the respective primary chiropractic provider.

(2) Permit any licensed chiropractor who agrees to abide by the terms, conditions, reimbursement rates, and standards of quality of the health benefit plan to serve as a participating primary chiropractic provider to any person covered by the plan.

(3) Guarantee that all covered persons who are eligible for chiropractic benefits under a health benefit plan shall have direct access to the primary chiropractic provider of their choice independent of, and without referral from, any other provider or entity.

(4) Assure that those plans utilizing a gatekeeper system shall designate the primary chiropractic provider within the scope of practice as the gatekeeper, who shall provide basic patient care and coordinate diagnostic testing, indicated treatment, and specialty referral for those covered persons in the provision of chiropractic benefits. Nothing in KRS 304.17A-170 or this section shall prevent a covered person from having direct access to that person's primary care provider (gatekeeper) for treatment and being reimbursed in accordance with the terms and fee schedule of the health benefit plan.

(5) Not discriminate between individual providers or classes of providers in the amount of reimbursement, copayment, or other financial compensation for the same or essentially similar services provided by the health benefit plan.

(6) Not promote or recommend any individual provider or class of providers to a covered person by any method or means.

(7) Assure that an adequate number of primary chiropractic providers are included as participating chiropractic providers to guarantee reasonable accessibility, timeliness of care, convenience, and continuity of care to covered persons.

(8) Make available to covered persons a listing of all participating primary chiropractic providers, their practice location and telephone number on a regular, timely basis.

Effective: July 15, 1996

History: Created 1996 Ky. Acts ch. 187, sec. 2, effective July 15, 1996.

304.17A-160 Repealed, 1998.

Catchline at repeal: Standard health benefit plans -- Written agreement required before provider may be represented as participating.

History: Repealed 1998 Ky. Acts ch. 496, sec. 62, effective July 1, 1999; amended 1998 Ky. Acts ch. 426, sec. 525, effective July 15, 1998. -- Amended 1996 Ky. Acts ch. 371, sec. 11, effective July 15, 1996. -- Created 1994 Ky. Acts ch. 512, sec. 59, effective July 15, 1994.

KYDepartment of Insurance

Location: 215 W. Main St. Frankfort, KY 40601 (800) 595-6053 TTY: (800) 462-2801

The following Advisory Opinion is to advise the reader of the current position of the Kentucky Department of Insurance ("the Department") on the specified issue. The Advisory Opinion is not legally binding on either the Department or the reader.

Kentucky Department of Insurance

Advisory Opinion 2000-01

In re: Providers Protected Under the Any Willing Provider Law

RELEVANT FACTS AND STATUTES: Questions have emerged concerning who is protected under KRS 304.17A-270, Kentucky's any willing provider law. The statutes that are relevant are KRS 304.17A-270, KRS 304.17A-250, KRS 304.17A-005(18), 806 KAR 17:180.

KRS 304.17A-250 required the commissioner to, "... by administrative regulations promulgated under KRS Chapter 13A, define one (1) standard health benefit plan that shall provide health insurance coverage in the individual and small group markets after June 30, 1998." In 806 KAR 17:180 the Department established the standard health benefit plan.

DEPARTMENT'S POSITION: It is the Department's position that the providers specifically listed in KRS 304.17A-005(18) that are willing to meet the health benefit plan's terms and conditions must be allowed to participate as a network provider. Every health benefit plan issued by an insurer must comply with the any willing provider law in relation to these providers. However, if a person is not specifically licensed as cited in KRS 304.17A-005(18) that person is not a provider for purposes of the any willing provider law.

In contrast, all the providers listed in the definition of provider in the standard health benefit plan, as defined in 806 KAR 17:180, must be allowed to participate as a network provider for the standard health benefit plan.

The Department, in developing the standard health benefit plan, sets the standards under which the plan is to operate. For this reason, the Department is of the opinion that all providers listed in the definition of provider found in the standard health benefit plan must be allowed to participate with that plan. Therefore, any such provider cannot be excluded from rendering services under the standard health benefit plan unless the provider does not meet any standards developed pursuant to KRS 304.17A-525.

Any questions regarding this matter may be directed to Shaun T. Orme, Counsel for the Department at (502) 564-6032.

_____

George Nichols III, Commissioner

Kentucky Department of Insurance

KYDepartment of Insurance

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Kentucky Department of Insurance

Advisory Opinion 2000-01

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The Department, in developing the standard health benefit plan, sets the standards under which the plan is to operate. For this reason, the Department is of the opinion that all providers listed in the definition of provider found in the standard health benefit plan must be allowed to participate with that plan. Therefore, any such provider cannot be excluded from rendering services under the standard health benefit plan unless the provider does not meet any standards developed pursuant to KRS 304.17A-525.

Any questions regarding this matter may be directed to Shaun T. Orme, Counsel for the Department at (502) 564-6032.

George Nichols III, Commissioner

Kentucky Department of Insurance

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Kentucky Department of Insurance

Advisory Opinion 99-08

In re: Any Willing Provider Law

RELEVANT FACTS AND STATUTES: Recently the Department has seen some issues regarding the application of the any willing provider law. The statutes involved are KRS 304.17A-005(17), 304.17A-005 (18), 304.17A-005(22), 304.17A-270, and 304.17A-525.

DEPARTMENT'S POSITION: KRS 304.17A-270 contains the any willing provider law. The statute says:

> A health insurer shall not discriminate against any provider who is located within the geographic coverage area of the health plan and is willing to meet the terms and conditions for participation established by the health insurer, including the Kentucky State Medicaid program and Medicaid partnerships.

The first step is to determine if the plan with which the provider seeks to contract is a health benefit plan [defined in KRS 304.17A-005(17)] offered by an insurer [defined in KRS 304.17A-005(22)]. If step one is satisfied, the second step is to determine if the provider seeking a contract with the health benefit plan is included in the definition of provider found in KRS 304.17A-005(18). Finally, if the first two steps are met and the provider is located in the geographic coverage area of the health benefit plan, the provider cannot be excluded if he/she is willing to meet the terms and conditions of contracting with the insurer.

KRS 304.17A-525 requires insurers to develop relevant, objective standards for initial consideration of providers and for providers to continue as a participating provider in the health benefit plan. It requires the terms and conditions to be based on relevant, objective standards.

The Department considers standards to be relevant and objective if the standards are uniformly applied to all providers within a given provider category (e.g., physicians) and based upon criteria that are reasonably related to the provider category for the provision of services. Examples include, but are not limited to, medical licensure, specialty board certification, medical malpractice history, valid DEA number, and hospital privileges.

The Department considers standards to not be relevant and objective if the standards are based upon criteria that are not reasonably related to the provision of services by that provider category. Examples include, but are not limited to, required membership in a certain professional organization, professional enhancements, a medical degree from a certain university, a certain age, race, gender, sexual orientation and disability. The Department considers limiting the number of providers in a provider category, based upon the determination that the insurer's network is adequate to be contrary to the law.

The Department will consider all circumstances in determining if standards are relevant and objective. The examples listed above are not an exclusive list. The Department may determine that a particular term and condition is not based on relevant and objective criteria, and in violation of the any willing provider law, based on a reason other than listed in this Advisory Opinion. This Opinion is intended to serve as a guide for plans in developing terms and conditions.

During the litigation in Health Maintenance Organization Association of Kentucky, Inc. et al. v. George Nichols III, Civil Action No. 97-24 the Department was precluded from enforcing the statute because the Court issued a stay on the enforcement of the law. However, the case was decided in the Department's

favor in August of 1998 and the stay is no longer in effect. The Department is now enforcing the any willing provider law.

Any questions concerning this matter may be directed to Shaun T. Orme, Counsel for the Department at (502)564-6032.

_____

George Nichols III

Commissioner

_____

Date

State of Wisconsin
2003 – 2004 LEGISLATURE

2923/P1
LRB-~~2655/1~~
PJK:jld:pg
keep

2003 BILL

Date

Regen

AN ACT ***to renumber*** 628.36 (2m) (a) 1., 628.36 (2m) (a) 2. and 628.36 (2m) (a) 3.; ***to renumber and amend*** 628.36 (1); ***to consolidate, renumber and amend*** 628.36 (2m) (a) (intro.) and 2m.; ***to amend*** 609.22 (2), 609.32 (2) (a), 628.36 (2) (a) (intro.), 628.36 (2) (b) 3. and 628.36 (3); and ***to create*** 628.36 (1c) (intro.) and 628.36 (2) (b) 4m. of the statutes; **relating to:** allowing any provider to participate in a health care plan under the terms of the plan.

Analysis by the Legislative Reference Bureau

However,

Under current law, a health care plan must allow any provider to participate in the plan under the terms of the plan. This requirement ~~however,~~ does not apply to health maintenance organizations, limited service health organizations, or preferred provider plans, each of which is a health care plan that requires, or provides incentives for, its enrollees to obtain health care services from providers participating in the plan. "Participating" is defined as being under contract to provide health care services, items, or supplies to plan enrollees.

This bill requires any health care plan, including a health maintenance organization, limited service health organization, or preferred provider plan, to allow any provider to participate in the plan under the terms of the plan. The requirement only applies to a health maintenance organization, limited service

health organization, or preferred provider plan, however, if the provider is located in the geographic service area of the plan.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are, to the extent consistent with s. 628.36 (2) (b) 3., accessible and qualified.

SECTION 2. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A defined network plan shall develop, [redacted] consistent with s. 628.36 (2) (b) 3., a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish, to the extent consistent with s. 628.36 (2) (b) 3., minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 3. 628.36 (1) of the statutes is renumbered 628.36 (1m) and amended to read:

628.36 **(1m)** PAYMENT METHODS. Any corporation operating a voluntary health care plan may pay health care professionals on a salary, per patient, or fee–for–service basis to provide health care to policyholders or beneficiaries of the corporation.

SECTION 4. 628.36 (1c) (intro.) of the statutes is created to read:

628.36 **(1c)** DEFINITIONS. (intro.) In this section:

SECTION 5. 628.36 (2) (a) (intro.) of the statutes is amended to read:

628.36 **(2)** (a) (intro.) In this ~~section~~ subsection:

SECTION 6. 628.36 (2) (b) 3. of the statutes is amended to read:

628.36 **(2)** (b) 3. Except as provided in ~~subd.~~ subds. 4. and 4m., and subject to sub. (2m) (e), no provider may be denied the opportunity to participate in a health care plan~~, other than a health maintenance organization, a limited service health organization or a preferred provider plan,~~ under the terms of the plan.

SECTION 7. 628.36 (2) (b) 4m. of the statutes is created to read:

628.36 **(2)** (b) 4m. Subdivision 3. applies to a health maintenance organization, limited service health organization, or preferred provider plan only with respect to a provider located in the geographic service area of the health maintenance organization, limited service health organization, or preferred provider plan.

SECTION 8. 628.36 (2m) (a) (intro.) and 2m. of the statutes are consolidated, renumbered 628.36 (2m) (ac) and amended to read:

628.36 **(2m)** (ac) In this subsection~~: 2m. "Pharmaceutical~~, "pharmaceutical services" do not include the administration of a drug product or device or vaccine under s. 450.035.

SECTION 9. 628.36 (2m) (a) 1. of the statutes is renumbered 628.36 (1c) (a).

SECTION 10. 628.36 (2m) (a) 2. of the statutes is renumbered 628.36 (1c) (b).

SECTION 11. 628.36 (2m) (a) 3. of the statutes is renumbered 628.36 (1c) (c).

SECTION 12. 628.36 (3) of the statutes is amended to read:

628.36 **(3)** EXEMPTION BY RULE. By rule the commissioner may exempt from the application of any part of subs. ~~(1)~~ (1m) to (2m) plans ~~which~~ that provide innovative

approaches to the delivery of health care or ~~which~~ that are designed to contain health care costs, and ~~which~~ that cannot operate successfully consistent with all of the provisions in subs. ~~(1)~~ (1m) to (2m). The commissioner may promulgate such a rule only if on a finding that the interests of the public require such plans as an experiment, to supply health care services that are not otherwise available in adequate quantity or quality, or to contain health care costs. The promulgated rule shall be as narrow as is compatible with the success of the plans.

(END)

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2923/1dn
PJK:...:...

Wisconsin actually has had an "any willing provider" law since 1975. Interestingly, the 1985 budget bill excluded health maintenance organizations (HMOs), preferred provider plans (PPPs), and limited service health organizations (LSHOs) from the requirement. This made Wisconsin's "any willing provider" law more or less meaningless. This bill removes the exclusion for HMOs, PPPs, and LSHOs.

For HMOs, PPPs, and LSHOs, I limited the requirement to providers located in the geographic service area of the plan. You may wish to delete this limitation.

Perhaps you would like to provide more oversight for compliance with the requirement. For example, you could require a plan to file with OCI written "terms of the plan" and allow OCI to disapprove the terms if they are too exclusionary. You could require a plan to provide to a provider that is denied participation in a plan written notice of the reason for the denial.

Would you like to require plans (or just HMOs, PPPs, and LSHOs) to provide an annual period during which any provider may elect to participate in the plan, as is the case for pharmacists under s. 628.36 (2m)?

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2655/1dn
PJK:jld:pg

May 15, 2003

Insert D 2

I have included amendments to ss. 609.22 (2) and 609.32 (2) (a) because there may be a conflict between those provisions and the change to s. 628.36 (2) (b) 3. Let me know if you think any further changes are needed in ch. 609 because of the change in this bill.

In addition to the substantive change, I moved the definitions of ~~health maintenance organization, limited service health organization~~, and ~~preferred provider plan~~ (which are in s. 628.36 (2m) (a) in current law) to the beginning of s. 628.36, since those definitions apply in sub. (2) of that section, also.

HMO PPP LSHO

Pamela J. Kahler
Senior Legislative Attorney
Phone: (608) 266–2682
E–mail: pam.kahler@legis.state.wi.us

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2923/P1dn
PJK:jld:rs

June 25, 2003

Wisconsin actually has had an "any willing provider" law since 1975. Interestingly, the 1985 budget bill excluded health maintenance organizations (HMOs), preferred provider plans (PPPs), and limited service health organizations (LSHOs) from the requirement. This made Wisconsin's "any willing provider" law more or less meaningless. This bill removes the exclusion for HMOs, PPPs, and LSHOs.

Perhaps you would like to provide more oversight for compliance with the requirement. For example, you could require a plan to file with OCI written "terms of the plan" and allow OCI to disapprove the terms if they are too exclusionary. You could require a plan to provide to a provider that is denied participation in a plan written notice of the reason for the denial.

Would you like to require plans (or just HMOs, PPPs, and LSHOs) to provide an annual period during which any provider may elect to participate in the plan, as is the case for pharmacists under s. 628.36 (2m)?

I have included amendments to ss. 609.22 (2) and 609.32 (2) (a) because there may be a conflict between those provisions and the change to s. 628.36 (2) (b) 3. Let me know if you think any further changes are needed in ch. 609 because of the change in this bill.

In addition to the substantive change, I moved the definitions of HMO, LSHO, and PPP (which are in s. 628.36 (2m) (a) in current law) to the beginning of s. 628.36, since those definitions apply in sub. (2) of that section, also.

Pamela J. Kahler
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DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–2923/P1dn
PJK:jld:rs

June 25, 2003

Per phone call from Tom Powell on Sept 10 → add these 2 additions

Wisconsin actually has had an "any willing provider" law since 1975. Interestingly, the 1985 budget bill excluded health maintenance organizations (HMOs), preferred provider plans (PPPs), and limited service health organizations (LSHOs) from the requirement. This made Wisconsin's "any willing provider" law more or less meaningless. This bill removes the exclusion for HMOs, PPPs, and LSHOs.

Perhaps you would like to provide more oversight for compliance with the requirement. For example, you could require a plan to file with OCI written "terms of the plan" and allow OCI to disapprove the terms if they are too exclusionary. You could require a plan to provide to a provider that is denied participation in a plan written notice of the reason for the denial.

Would you like to require plans (or just HMOs, PPPs, and LSHOs) to provide an annual period during which any provider may elect to participate in the plan, as is the case for pharmacists under s. 628.36 (2m)?

I have included amendments to ss. 609.22 (2) and 609.32 (2) (a) because there may be a conflict between those provisions and the change to s. 628.36 (2) (b) 3. Let me know if you think any further changes are needed in ch. 609 because of the change in this bill.

In addition to the substantive change, I moved the definitions of HMO, LSHO, and PPP (which are in s. 628.36 (2m) (a) in current law) to the beginning of s. 628.36, since those definitions apply in sub. (2) of that section, also.

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State of Wisconsin
2003 – 2004 LEGISLATURE

LRB–2923/1
PJK:jld:rs

PRELIMINARY DRAFT – NOT READY FOR INTRODUCTION

AN ACT *to renumber* 628.36 (2m) (a) 1., 628.36 (2m) (a) 2. and 628.36 (2m) (a) 3.; *to renumber and amend* 628.36 (1); *to consolidate, renumber and amend* 628.36 (2m) (a) (intro.) and 2m.; *to amend* 609.22 (2), 609.32 (2) (a), 628.36 (2) (a) (intro.), 628.36 (2) (b) 3. and 628.36 (3); and *to create* 628.36 (1c) (intro.) and 628.36 (2) (b) 4m. of the statutes; **relating to:** allowing any provider to participate in a health care plan under the terms of the plan.

Analysis by the Legislative Reference Bureau

Under current law, a health care plan must allow any provider to participate in the plan under the terms of the plan. However, this requirement does not apply to health maintenance organizations, limited service health organizations, or preferred provider plans, each of which is a health care plan that requires, or provides incentives for, its enrollees to obtain health care services from providers participating in the plan. "Participating" is defined as being under contract to provide health care services, items, or supplies to plan enrollees.

This bill requires any health care plan, including a health maintenance organization, limited service health organization, or preferred provider plan, to allow any provider to participate in the plan under the terms of the plan. The requirement only applies to a health maintenance organization, limited service

health organization, or preferred provider plan, however, if the provider is located in the geographic service area of the plan. Insert 2-A

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 609.22 (2) of the statutes is amended to read:

609.22 **(2)** ADEQUATE CHOICE. A defined network plan that is not a preferred provider plan shall ensure that, with respect to covered benefits, each enrollee has adequate choice among participating providers and that the providers are, to the extent consistent with s. 628.36 (2) (b) 3. and (2m) accessible and qualified.

SECTION 2. 609.32 (2) (a) of the statutes is amended to read:

609.32 **(2)** (a) A defined network plan shall develop, consistent with s. 628.36 (2) (b) 3. and (2m), a process for selecting participating providers, including written policies and procedures that the plan uses for review and approval of providers. After consulting with appropriately qualified providers, the plan shall establish, to the extent consistent with s. 628.36 (2) (b) 3. and (2m), minimum professional requirements for its participating providers. The process for selection shall include verification of a provider's license or certificate, including the history of any suspensions or revocations, and the history of any liability claims made against the provider.

SECTION 3. 628.36 (1) of the statutes is renumbered 628.36 (1m) and amended to read:

628.36 **(1m)** PAYMENT METHODS. Any corporation operating a voluntary health care plan may pay health care professionals on a salary, per patient, or fee–for–service basis to provide health care to policyholders or beneficiaries of the corporation.

SECTION 4. 628.36 (1c) (intro.) of the statutes is created to read:

628.36 **(1c)** DEFINITIONS. (intro.) In this section:

SECTION 5. 628.36 (2) (a) (intro.) of the statutes is amended to read:

628.36 **(2)** (a) (intro.) In this ~~section~~ subsection:

SECTION 6. 628.36 (2) (b) 3. of the statutes is amended to read:

628.36 **(2)** (b) 3. Except as provided in ~~subd.~~ subds. 4. and 4m., and subject to sub. (2m) (e), no provider may be denied the opportunity to participate in a health care plan~~, other than a health maintenance organization, a limited service health organization or a preferred provider plan,~~ under the terms of the plan.

SECTION 7. 628.36 (2) (b) 4m. of the statutes is created to read:

628.36 **(2)** (b) 4m. Subdivision 3. applies to a health maintenance organization, limited service health organization, or preferred provider plan only with respect to a provider located in the geographic service area of the health maintenance organization, limited service health organization, or preferred provider plan.

SECTION 8. 628.36 (2m) (a) (intro.) and 2m. of the statutes are consolidated, renumbered 628.36 (2m) (ac) and amended to read:

628.36 **(2m)** (ac) In this subsection~~: 2m. "Pharmaceutical, "pharmaceutical~~ services" do not include the administration of a drug product or device or vaccine under s. 450.035.

SECTION 9. 628.36 (2m) (a) 1. of the statutes is renumbered 628.36 (1c) (a).

SECTION 10. 628.36 (2m) (a) 2. of the statutes is renumbered 628.36 (1c) (b).

SECTION 11. 628.36 (2m) (a) 3. of the statutes is renumbered 628.36 (1c) (c).

SECTION 12. 628.36 (3) of the statutes is amended to read:

628.36 **(3)** EXEMPTION BY RULE. By rule the commissioner may exempt from the application of any part of subs. ~~(1)~~ (1m) to (2m) plans ~~which~~ that provide innovative approaches to the delivery of health care or ~~which~~ that are designed to contain health

care costs, and ~~which~~ that cannot operate successfully consistent with all of the provisions in subs. ~~(1)~~ (1m) to (2m). The commissioner may promulgate such a rule only if on a finding that the interests of the public require such plans as an experiment, to supply health care services that are not otherwise available in adequate quantity or quality, or to contain health care costs. The promulgated rule shall be as narrow as is compatible with the success of the plans.

(END)

INSERT 2–A

not The bill also requires a health care plan that excludes a provider from participation in the plan to give the provider written notice of the reason for the exclusion.

Also under current law, a health maintenance organization, limited service health organization, or preferred provider plan that covers pharmaceutical services provided by one or more pharmacists who are not full–time salaried employees or partners of the organization or plan must provide an annual 30–day period during which any pharmacist may elect to participate in the organization or plan under its terms as a selected provider for at least one year. This bill expands that requirement. Under the bill, a health maintenance organization, limited service health organization, or preferred provider plan that covers health care services that are provided by one or more health care professionals who are not full–time salaried employees or partners of the organization or plan is required to provide an annual 30–day period during which any health care professional who provides those health care services and who is located in the geographic service area of the organization or plan may elect to participate in the organization or plan under its terms as a selected provider for at least one year.

(END OF INSERT 2–A)

INSERT 3–8

SECTION 1. 628.36 (2) (b) 4. of the statutes is amended to read:

628.36 **(2)** (b) 4. Any health care plan may exclude a provider from participation in the health care plan for cause related to the practice of his or her profession. A health care plan that excludes a provider from participation shall advise the provider in writing of the reason for the exclusion.

History: 1975 c. 223, 371, 422; 1983 a. 27, 192, 321, 396; 1985 a. 29; 1987 a. 27; 1989 a. 31, 215; 1991 a. 250; 1997 a. 27, 68; 1997 a. 237 s. 727m.

(END OF INSERT 3–8)

INSERT 3–13

SECTION 2. 628.36 (2m) (title) of the statutes is repealed and recreated to read:

628.36 **(2m)** (title) ANNUAL PARTICIPATION ELECTION PERIOD.

(END OF INSERT 3–13)

~~INSERT 3–21~~

Ins. 3-21

SECTION 3. 628.36 (2m) (e) 1. of the statutes is amended to read:

628.36 **(2m)** (e) 1. A health maintenance organization, limited service health organization, or preferred provider plan that provides coverage of ~~pharmaceutical~~ health care services ~~when~~ that are performed by one or more ~~pharmacists~~ health care professionals who are selected by the organization or plan but who are not full–time salaried employees or partners of the organization or plan shall provide an annual period of at least 30 days during which any ~~pharmacist registered under ch. 450~~ health care professional who provides those health care services, who has been granted a credential, as defined in s. 440.01 (2) (a), to practice in this state, and who is located in the geographic service area of the organization or plan may elect to participate in the health maintenance organization, limited service health organization, or preferred provider plan under its terms as a selected provider for at least one year.

History: 1975 c. 223, 371, 422; 1983 a. 27, 192, 321, 396; 1985 a. 29; 1987 a. 27; 1989 a. 31, 215; 1991 a. 250; 1997 a. 27, 68; 1997 a. 237 s. 727m.

SECTION 4. 628.36 (2m) (e) 2. of the statutes is amended to read:

628.36 **(2m)** (e) 2. Except as provided in subd. 3., subd. 1. applies to health maintenance organizations ~~on and after May 10, 1984. Except as provided in subd. 4., subd. 1. applies to,~~ limited service health organizations, and preferred provider plans on or after ~~April 28, 1990~~ the effective date of this subdivision .... [revisor inserts date].

History: 1975 c. 223, 371, 422; 1983 a. 27, 192, 321, 396; 1985 a. 29; 1987 a. 27; 1989 a. 31, 215; 1991 a. 250; 1997 a. 27, 68; 1997 a. 237 s. 727m.

SECTION 5. 628.36 (2m) (e) 3. of the statutes is amended to read:

628.36 **(2m)** (e) 3. If compliance with the requirements of subd. 1. during the period specified in subd. 2. would impair any provision of a contract between a health maintenance organization, limited service health organization, or preferred provider plan and any other person, and if the contract provision was in existence

INS 3-21 cont

prior to ~~May 10, 1984~~ the effective date of this subdivision .... [revisor inserts date], then immediately after the expiration of all such contract provisions the health maintenance organization, limited service health organization, or preferred provider plan shall comply with the requirements of subd. 1.

History: 1975 c. 223, 371, 422; 1983 a. 27, 192, 321, 396; 1985 a. 29; 1987 a. 27; 1989 a. 31, 215; 1991 a. 250; 1997 a. 27, 68; 1997 a. 237 s. 727m.

SECTION 6. 628.36 (2m) (e) 4. of the statutes is repealed.

(END OF INSERT 3–21)

Northrop, Lori

From: Powell, Thomas
Sent: Wednesday, September 24, 2003 2:08 PM
To: LRB.Legal
Subject: Draft review: LRB 03-2923/1 Topic: Allow "any willing provider" to join network

It has been requested by <Powell, Thomas> that the following draft be jacketed for the ASSEMBLY:

Draft review: LRB 03-2923/1 Topic: Allow "any willing provider" to join network